Beyond Biologics

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize Beyond Biologics to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize Beyond Biologics to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional.

This authorization is effective now and will be in effect for the time that I am a patient of Beyond Biologics or until I revoke it in writing.

Beyond Biologics reserves the right to modify the privacy practices outlined in the notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPAA guidelines for the office of Beyond Biologics was made available to me to read at beyondbiologics.com. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship to Patient: _____Date of Birth: _____

NAME: _____ Relationship to Patient: _____Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" on _____.
The acknowledgement was not obtained because:

___ The patient was undergoing emergency treatment.
___ The patient declined to sign the acknowledgement.
___ Other

Name of Staff Member: _____ Date: _____